

Case Number:	CM15-0033834		
Date Assigned:	02/27/2015	Date of Injury:	01/20/2014
Decision Date:	04/13/2015	UR Denial Date:	02/12/2015
Priority:	Standard	Application Received:	02/23/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 46-year-old male, who sustained an industrial injury on 1/20/14. On 2/23/15, the injured worker submitted an application for IMR for review of Functional Restoration Program 6 weeks. The treating provider has reported the injured worker complained of pain in left forearm and wrist, left shoulder and cervical spine. The diagnoses have included contusion forearm; crush injury to forearm; other affections to shoulder region; chronic pain syndrome; carpal tunnel syndrome; lesion ulnar nerve; sprain/strain neck; mononeuritis arm; cervico brachial syndrome. Treatment to date has included TENS unit, glove, Stellate ganglion block (11/11/14); MRI left shoulder (12/30/14); EMG/NCV upper extremity (10/27/2014) and medication. On 2/12/15 Utilization Review non-certified Functional Restoration Program 6 weeks. The MTUS Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Functional Restoration Program 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs (functional restoration programs) Page(s): 31-32.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Programs Page(s): 30-32.

Decision rationale: This patient presents with left shoulder, upper extremity, left forearm and wrist pain. The treater is requesting a FUNCTIONAL RESTORATION PROGRAM SIX WEEKS. The RFA was not made available for review. The patient's date of injury is from 01/20/2014 and he is currently temporarily very disabled. The MTUS Guidelines page 30 to 32 recommends Functional Restoration Programs when all of the following criteria are met including: 1. Adequate and thorough evaluation has been made. 2. Previous methods of treating chronic pain had been unsuccessful. 3. Significant loss of the ability to function independently resulting from chronic pain. 4. Not a candidate for surgery or other treatments would clearly be warranted. 5. The patient exhibits motivation change. 6. Negative predictor of success above has been addressed. These negative predictors include evaluation for poor relationship with employer, work satisfaction, negative outlook in the future, etc. The MTUS guidelines page 30 - 33 on chronic pain programs -functional restoration programs- states, "treatment duration in excess of 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans and proven outcomes, and should be based on chronicity of disability and other known risk factors for loss of function." The medical records show that patient has not attended a functional restoration program in the past. The 02/02/2015 progress report shows that the patient continues to complain of increasing pain in the dorsal midportion of the proximal hand with aching, burning pain in the volar aspect of the wrist. The right shoulder is down one cm. Extension and rotation of the left causes moderate discomfort in the right junction and paravertebral musculature in the CT Spine. Tinel's sign is positive on the left. The patient has utilized medication and TENS unit in the past. The treater has not discussed negative predictors and the patient's motivation to change. An assessment has not been completed. In this case, the patient has not met all the required criteria for admission to a functional restoration program. Furthermore the requested six week duration exceeds and MTUS guidelines. The request IS NOT medically necessary.